Michigan Department of Community Health

FACILITY ADMISSION NOTICE (MSA-2565-C)

INSTRUCTIONS

GENERAL INSTRUCTIONS/DISTRIBUTION:

- The MSA-2565-C serves as notice of admission of a beneficiary (or potential beneficiary). It must be completed for potentially eligible Medicaid beneficiaries of all ages.

- The facility must retain **THE ORIGINAL** of the Facility Admission Notice in the beneficiary's file. A copy **MUST** be sent to the Local FIA Office.

- A copy of the MSA-2565-C will be returned to the facility, noting the eligibility status and patient pay amount of the resident.

Authority: P.A. 280 of 1939 and Federal 42 CFR of 435
Title XIX of the Social Security Act
Completion: Is Voluntary
Penalty: None, but a medical eligibility determination would be delayed

Michigan Department of Community Health

FACILITY ADMISSION NOTICE

1. Patient Name *(Last, First, Middle)*	2.Gender ☐ M ☐ F	3. Birth Date / /	4. Social Security No. – –
5. Home Address *(No. & Street including apartment number)*	City	State	Zip Code
6. Name of Person Responsible for Patient *(Last, First, Middle)*	7. Phone No. ( ) –		8. Relationship to Patient
9. Home Address *(No. & Street including apartment number)*	City	State	Zip Code

10. Name of Provider			12. Provider ID No.
11. Provider Address *(No. & Street)*			13. Attending Physician Name
City	State	Zip Code	14. Hospital Case No. *(If Applicable)*

15. Type of Facility *(Check ONE)*

☐ Hospital ☐ Long Term Care (in Hospital) ☐ Nursing Facility ☐ ICF/MR Care (in AIS Facility)
☐ Special MR Nursing Facility ☐ ICF/MR Care (in DCH Facility) ☐ Medical Care Facility ☐ Psychiatric Care (in DCH Facility)
☐ Other (Explain) _____

16. Date of Admission / /	17. If LTC Facility, Specify Private Rate $ _____ per diem amount	18. Is this Admission Likely to be 30 days or Longer? ☐ NO ☐ YES (If YES, Estimate Total Length of Stay) _____

19. Present Status of Patient *(Check ONE)*

☐ Still a Patient ☐ Discharged (Date): / / ☐ Deceased (Date): / /

20. Primary Diagnosis	21. Secondary Diagnosis

22. Patient Admitted to Facility From: *(Check ONE)*

☐ Home ☐ Long Term Care Facility/Unit ☐ AFC/ Home for the Aged ☐ Other (Specify) _____
☐ Hospital (Enter applicable dates) Admission Date / / Discharge Date / /

23. Indicate Medicare or Private Health Insurance coverage available to patient and complete the following as applicable

☐ Medicare ☐ No Other Insurance Coverage Available
☐ Private Health Insurance (Complete Items 24 thru 29 below) ☐ Private LTC Coverage (Complete Items 30 thru 35 below)

24. Name of Policyholder (Private Health Ins.)	25. Policyholder's SS No. – –	30. Name of Policyholder (Private LTC Ins.)	31. Policyholder's SS No. – –
26. Name of Insurance Company		32. Name of Insurance Company	
27. Location (City) / State / Zip Code		33. Location (City) / State / Zip Code	
28. Group / Policy Number	29. Cert. / Contract No.	34. Group / Policy Number	35. Cert. / Contract No.

PATIENT CERTIFICATION

I certify that the information furnished by me in applying for skilled nursing facility, other long term care, or hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in section **10** above, the name(s) and address (es) of all parties liable or who may be liable in whole or in part for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible in whole or in part for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.

36. Signature of Patient or Patient's Representative Date Signed / /	37. Signature of Person Completing This Form Date Signed / /

STATEMENT OF ELIGIBILITY (To be completed by MDCH / FIA for MA eligibility)

Eligibility is:

☐ **DENIED** (Contact Patient or Patient's Representative for Explanation) ☐ **APPROVED** (See the Billing Information Below)

Eligible Person's Name / Program		Grantee Name				
Recipient ID No.	MA Eligibility Effective Date	Grantee Client ID No.				FIA Case No.
Patient Pay Amount $	Patient Pay Amt. Effective Date	County	District	Section	Unit	Worker Name
Insurance, Medicare, Third Party Name		Signature of Worker				

MSA-2565-C (01-05) Previous editions may be used.